MAP-246
(Rev 6/09)

Agreement Between the Kentucky Department for Medicaid Services And Electronic Media Billing Agency

This agreement regards the submission of claims via electronic media to the Kentucky Medicaid Program (KMP).

The_____ has entered into a contract with
(Name of Billing Agency)

_____, _____,
(Name of Provider) (Provider Number)

_____ to submit claims via electronic media for service provided to KMP recipients.
(National Provider Identifier [NPI])

The billing agency agrees:

1. Billing Agency also agrees to maintain appropriate security safeguards and means it feels are necessary regarding the electronic, physical and administrative protection of data in accordance with the HIPAA Security Standards once finalized.
2. To maintain or have access to a record of all claims submitted for payment for a period of at least six (6) years, and to provide this information to the KMP or designated agents of the KMP upon request;
3. To submit claim information as directed by the provider and in compliance with the HIPAA transaction and code set regulations by the appropriate due date, understanding the submission of an electronic media claim is a claim for Medicaid payment and that any person who, with intent to commit fraud or deceive, makes or causes to be made or assists in the preparation of any false statement, misrepresentation or omission of a material fact in any claim or application for any payment, regardless of amount, knowing the same to be false, is subject to civil and/or criminal sanctions under applicable state and federal statutes.
4. To maintain on file an authorized signature from the provider, authorizing all billings submitted to the KMP or its agents.
5. To protect the confidentiality of data and the privacy rights of the recipients whose data is transported in accordance with HIPAA privacy regulations with their provider's business associate agreement. Billing agency agrees to take "reasonable steps" to cure the breach or to end any uncovered violations of confidentiality or security of data under their control.

The Department for Medicaid Services agrees:

1. To assign a code to the billing agency to enable the media to be processed;
2. To reimburse the provider in accordance with established policies.
3. To maintain appropriate security safeguards and means it feels are necessary regarding the electronic, physical and administrative protection of data in accordance with HIPAA Security Standards once finalized.
4. To protect the confidentiality of data and the privacy rights of the recipients whose data is transported in accordance with HIPAA privacy regulations.

This agreement may be terminated upon written notice by either party without cause.

This is to certify that the foregoing information is true, accurate, and complete.

I understand that payment of claims will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

_____
SIGNATURE, AUTHORIZED AGENT OF BILLING AGENCY

_____
DATE

_____
CONTACT PERSON (FIRST AND LAST NAME)

_____
TELEPHONE NUMBER

MEDIA: ☐ POS ☐ PC to PC ☐ CD

Please return form to:
Electronic Claims Submission,
P.O. Box 2016
Frankfort, KY 40602-2016